DEPARTMENT OF ALCOHOL AND DRUG PROGRAMS
1700 K STREET
SACRAMENTO, CA 95814-4037
TDD (916) 445-1942
(916) 322-7012

Date: April 8, 2005

To: Alcohol and Drug Treatment Providers in Los Angeles and Sacramento Counties

From: Michael S. Cunningham, CARE Project Director

Subject: Invitation to Participate in the California Access to Recovery Effort Program

The purpose of this letter is to invite you to submit an application for participation in the California Access to Recovery Effort (CARE) program. The Department of Alcohol and Drug Programs (ADP) is currently accepting applications from ADP-certified treatment programs in Los Angeles and Sacramento Counties to become authorized CARE treatment providers. In addition to being certified by ADP as meeting the *Alcohol and Other Drug Program Certification Standards*, providers must have staff who are experienced and qualified to serve substance abusing youth and comply with ADP's *Youth Treatment Guidelines*.

The CARE program is funded by a three-year federal grant and will provide vouchers to substance abusing 12-20 year olds in Los Angeles and Sacramento Counties for AOD treatment and recovery support services. Eligible youth will be able to choose a provider that meets their needs and preferences from a network of programs located in one of the two target counties. CARE vouchers will be issued beginning May 31, 2005.

Approved treatment providers will accept vouchers from CARE clients who chose their services, based on appropriate options presented to them during the assessment process. Treatment providers will provide allowable services as authorized by the voucher and specified in the treatment plan developed by the provider and the client. Providers will be paid monthly in arrears, after submitting service data.

An overview of the program with requirements for provider participation is enclosed. The requirements are based on specifications in the Access to Recovery Program Notice of Funding Announcement published by the Substance Abuse and Mental Health Services Administration in March 2004, and in ADP's grant application. A more detailed policies and procedures manual will be distributed to providers once they are approved for participation. Also, you can access ADP's *Youth Treatment Guidelines* online at www.adp.ca.gov/youth/pdf/Youth_Treatment_Guidelines.PDF .

The application process will remain open continuously until further notice. To apply, please complete and submit one original hardcopy of the enclosed application to the address shown below:

CARE Program
Department of Alcohol and Drug Programs
1700 K Street, 4th Floor
Sacramento, CA 95814

ADP will notify providers of eligibility status within 30 days of receipt of a complete application. Incomplete applications will delay the approval process. Following application approval, your agency will also receive training related to CARE program requirements.

Initial training for treatment providers is scheduled as follows:

Sacramento Training
May 10, 2005
9 a.m. to 4:30 p.m.
Sacramento County Elections and Sheriff's Office
7000 65th Street
Sacramento, CA

Los Angeles Training:
May 25, 2005
9 a.m. to 4:30 p.m.
Alhambra Auditorium
1000 South Fremont Avenue
Alhambra, CA

A flyer with more detailed information about the training will be sent to you when your application is approved. The training will cover the following topics:

- An overview of the CARE program;
- Program requirements and roles and responsibilities;
- Program processes;
- The web-based CARE system;
- Performance objectives;
- Billing and reimbursement processes; and
- Data collection and reporting requirements.

ADP encourages all qualified organizations to apply to become CARE program providers. By expanding the array of services and providers and giving consumers a choice, together we can make a difference in our communities and in the lives of youth affected by substance abuse and addiction.

If you have questions or need additional information, please contact Sue Heavens, CARE Project Coordinator, at (916) 445-0323.

Enclosures: CARE Program Overview
Treatment Provider Application

cc: Toni Moore, Sacramento County Alcohol and Drug Program Administrator
Patrick Ogawa, Los Angeles County Alcohol and Drug Program Administrator
Gregg Murakami, Los Angeles County Adolescent Treatment Coordinator
Marguerite Story-Baker, Sacramento County Youth Treatment Coordinator

State of California – Health and Human Services Agency
Department of Alcohol and Drug Programs

CALIFORNIA ACCESS TO RECOVERY EFFORT (CARE)

PROGRAM APPLICATION FOR TREATMENT SERVICE PROVIDERS

Instructions
Please type or print legibly and mail completed application to: **Department of Alcohol and Drug Programs, CARE Program, 1700 K Street, 4th Floor, Sacramento, CA 95814.** Retain a copy of the completed application for your files. Questions can be directed to Sue Heavens at (916) 445-0323.

SECTION 1: PROGRAM INFORMATION SHEET

PROGRAM NAME:_____

DOING BUSINESS AS (DBA) NAME:_____

TAX ID NUMBER (TIN):_____

ADDRESS: _____
(location where services will be provided)

MAILING ADDRESS:_____
(If different from above)

Will services to voucher recipients be provided at other locations? **Yes [ ] No [ ]**
If yes, please fill out the attached ***Program Information Sheet Addendum*** for each additional service location.

Please list the following contact/referral information for the CARE Program Directory.

CONTACT NAME:_____

PHONE: _____ **TOLL FREE #**:_____

FAX: _____ **TTY**:_____

EMAIL: _____

WEBSITE:_____

Do you want a link to this website on the CARE Program Directory? **Yes [ ] No [ ]**

Please list the following contact information for all other program inquiries (if different from above)

CONTACT NAME:_____

PHONE: _____ **TOLL FREE #**:_____

FAX: _____ **TTY**:_____

EMAIL: _____

HOURS OF OPERATION

24-hour facility? **Yes [ ] No [ ]** If "no," provide specific hours of operation:

Monday: _____Friday: _____
Tuesday: _____ Saturday:_____
Wednesday:_____ Sunday:_____
Thursday: _____

CORPORATE STATUS

[ ] Profit Corporation [ ] Nonprofit Corporation [ ] Governmental Entity

[ ] Sole Proprietor [ ] Partnership

TYPE OF ORGANIZATION

[ ] Advocacy group
[ ] Business/employer
[ ] Community-based organization
[ ] Education/training
[ ] Faith-based organization
[ ] Healthcare provider
[ ] County/city government

PREFERRED GROUPS SERVED/PROGRAM SPECIALTIES (check all that apply)

[ ] 12-17 year olds
[ ] 18-20 year olds
[ ] Female only
[ ] Male only
[ ] Dual diagnosis
[ ] Families
[ ] Specific language capacity (please list):_____
[ ] Specific culture (please list):_____

TREATMENT SERVICES OFFERED (check all that apply)

[ ] Outpatient treatment
[ ] Intensive outpatient treatment
[ ] Adult residential treatment (Department of Alcohol and Drug Programs-licensed)
[ ] Adolescent residential treatment (Department of Social Services-licensed)

SERVICE AREA (check one only)

[ ] Entire Los Angeles County
[ ] Selected zip codes in Los Angeles County (please list):_____
_____
[ ] Entire Sacramento County
[ ] Selected zip codes in Sacramento County (please list):_____
_____

LICENSE AND/OR CERTIFICATION

ADP certification number: _____

ADP license number: _____

Department of Social Services license number:_____

PROGRAM PROFILE

The following program information will be made available to clients to assist them select providers whose services reflect their needs and personal preferences. The information will be part of the CARE Program Directory available on the website or through the call-in center. Please be as descriptive as possible to help clients make appropriate, informed choices. However, the entire program profile should not exceed one double-spaced, typewritten page.

Program Mission and Philosophy Statement

Please attach a written statement(s) describing the program's mission and/or philosophy.

Program Description

Please provide a description of the services offered by the program, the settings in which they are offered, the type of client appropriate for the program's services, and the program's approach to treatment and recovery.

AUTHORIZED SIGNATURE

The undersigned affirms that the facts contained in this application and supporting documents are true and correct.

If the applicant is a **sole proprietor**, the proprietor must sign the application.
If the applicant is a **partnership**, each partner must sign the application
If the applicant is a **firm, association, corporation, or governmental entity**, the chief executive officer or the individual legally responsible for representing the firm, association, corporation or governmental entity must sign the application. The application must include the resolution or board minutes authorizing the individual to sign.

Name Typed: _____

Title: _____

Signature: _____

Date: _____

SECTION 2: PROGRAM INFORMATION SHEET ADDENDUM

Complete the sections below if you have additional or different locations. Please fill out one addendum for each additional service delivery location.

Please list the following contact/referral information for the CARE Program Directory.

CONTACT NAME: _____

PHONE: _____ **TOLL FREE #**: _____

FAX: _____ **TTY**: _____

EMAIL: _____

WEBSITE: _____

Do you want a link to this website on the CARE Program Directory? **Yes [ ] No [ ]**

Please list the following contact information for all other program inquiries (if different from above)

CONTACT NAME: _____

PHONE: _____ **TOLL FREE #**: _____

FAX: _____ **TTY**: _____

EMAIL: _____

HOURS OF OPERATION: 24-hour facility? **Yes [ ] No [ ]**

If "no," provide specific hours of operation:
Monday: _____ Friday: _____
Tuesday: _____ Saturday: _____
Wednesday:_____ Sunday: _____
Thursday: _____

PREFERRED GROUPS SERVED/PROGRAM SPECIALTIES (check all that apply)

[ ] 12-17 year olds
[ ] 18-20 year olds
[ ] Female only
[ ] Male only
[ ] Dual diagnosis
[ ] Families
[ ] Specific language capacity (please list):_____
[ ] Specific culture (please list):_____

TREATMENT SERVICES OFFERED (check all that apply)

[ ] Outpatient treatment
[ ] Intensive outpatient treatment
[ ] Adult residential treatment (Department of Alcohol and Drug Programs-licensed)
[ ] Adolescent residential treatment (Department of Social Services-licensed)

SERVICE AREA (check one only)

[ ] Entire Los Angeles County
[ ] Selected zip codes in Los Angeles County (please list):_____
_____
[ ] Entire Sacramento County
[ ] Selected zip codes in Sacramento County (please list):_____
_____

LICENSURE AND/OR CERTIFICATION

ADP certification number:_____

ADP license number:_____

Department of Social Services license number:_____

SECTION 3: DOCUMENTATION REQUIREMENTS FOR TREATMENT PROVIDERS

Residential Treatment Providers

Please attach the following:

- A signed copy of the Program Information Sheet (Section 1)
- If the organization is applying for more than one service location, a copy of the Program Information Sheet Addendum (Section 2)
- A copy of the organization's current certification(s) from ADP as evidence of compliance with the AOD program standards
- Either a copy of the organization's current license from ADP as an adult alcohol and drug program facility or a copy of the organization's current license from the California Department of Social Services as a group home facility
- A signed Program Acknowledgements page (Section 4)
- A signed Self-Certification of Compliance with ADP's Youth Treatment Guidelines (Section 5)
- A completed Staff Qualifications page (Section 6)

Outpatient Treatment Providers

Please attach the following:

- A signed copy of the Program Information Sheet (Section 1)
- If the organization is applying for more than one service location, a copy of the Program Information Sheet Addendum (Section 2)
- A copy of the organization's current certification(s) from ADP as evidence of compliance with the AOD program standards
- A signed Program Acknowledgements page (Section 4)
- A signed Self-Certification of Compliance with ADP's Youth Treatment Guidelines (Section 5)
- A completed Staff Qualifications page (Section 6)

SECTION 4: PROGRAM ACKNOWLEDGEMENTS PAGE

The undersigned acknowledges that he/she understands their organization's role and general responsibilities under the CARE program, as described in the CARE Program Overview, and agrees to comply with the requirements listed therein and summarized below:

- Offer consumers individual choice as to service provider.
- Accept vouchers from clients who are appropriate for the provider's services, as long as there is available capacity.
- Utilize staff with the necessary qualifications, training, and knowledge to treat substance abusing youth.
- Accept the authorized services and rates offered by the CARE program and be reimbursed after services are provided;
- Participate in performance assessments and regional performance meetings.
- Participate in training provided by MAXIMUS and/or ADP to carry out the duties and responsibilities under the program.
- Notify MAXIMUS whenever there are changes to program information, such as a change in program location, contact information, types of services offered, hours of operation, etc.
- Provide information to voucher clients regarding the availability of ADP to assist in resolving disputes between the provider and the client.
- Secure and protect the privacy and confidentiality of client information in accordance with HIPAA and 42 CFR.
- Collect all mandated data and report such data to MAXIMUS within the specified timeframes.

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

SECTION 5: SELF-CERTIFICATION OF COMPLIANCE WITH ADP'S YOUTH TREATMENT GUIDELINES

The undersigned has read the *Youth Treatment Guidelines* and agrees to comply with the overarching principles for effective AOD treatment for youth reflected in the *Guidelines* and as summarized below:

- Comprehensive and integrated services for youth. These include best practices related to assessment, treatment planning, counseling, youth development approaches, family interventions and support systems, educational and vocational activities, structured recovery related activities, alcohol and drug testing, discharge planning, and continuing care;

- Adherence to health and safety concerns (care and supervision of minors, medication management, emergency services, detoxification, background clearances for staff and volunteers);

- Appropriate service coordination and collaboration (case management and complementary services, critical linkages);

- Cultural, language, developmental, age, and gender competence;

- Compliance with applicable laws and regulations related to legal and ethical issues (consent, confidentiality, criminal reporting, client rights, grievance procedures);

- Qualified staff; and

- Administrative infrastructure (program rules and procedures, data collection and reporting).

PRINTED NAME: _____

SIGNATURE: _____

DATE: _____

SECTION 6: STAFF QUALIFICATIONS

Describe the minimum qualifications and/or training required of program staff:

_____

_____

_____

List the names of staff who will deliver voucher services to youth and attach a resume for each person.

Name of Staff	Qualifications